your health
NETWORK
A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS
December 2006 Volume 14, Number 2

inside

Keep Your Beneficiary Current

State Plan Active Employees Only

Do you know who would receive the proceeds from your state life insurance policy if you were to die? If you have not kept your beneficiary current, the answer to that question may not be who you think.

You may need to change your beneficiary if you have experienced a family status change. This could include marriage, divorce, childbirth or the death of your designated beneficiary. If you have encountered one or more of these types of events and aren't sure whether or not you changed your beneficiary, it would be a good idea to check with your agency insurance preparer. In order for a beneficiary to receive any proceeds, the proper paperwork must be completed and filed. Changes cannot be made over the phone.

All active state employees who have health insurance automatically have basic term life and special accident insurance as well (amounts of coverage vary based on age and salary). You may also have optional special accident, optional term or optional universal life insurance. Your beneficiary must be designated separately for each policy.

Often, when individuals remove a spouse from health coverage due to divorce or change their retirement beneficiary, they think this will remove the individual's status as a beneficiary on a life insurance policy as well. This is not true. The insurance company is legally obligated to pay benefits to the beneficiary we have on record, regardless of your present family status. Please make sure this designation is current.

This notice applies to active state employees only. Retiree and COBRA participants cannot continue life insurance through the state after termination of employment; however, optional term and optional universal life coverages may be continued on a direct pay basis to the insurance company under different terms and conditions. For the basic term life coverage you will be given an opportunity to exercise a conversion option. This coverage will not be the same as that provided to you as an employee. The necessary paperwork will automatically be sent to you at your home address four to six weeks after your coverage ends. Application must be made directly to the insurance company.

If you are no longer employed and are continuing life insurance on a direct pay basis to the insurance company, you must contact their customer service office to determine your designated beneficiary.

What Are Your Well-Care Benefits

We all know that our health insurance is there to help us in the event of injury and illness. But what about preventive care? Did you know that your health insurance provides benefits for well-care services designed to keep you and your family members healthy?

Simple shots and vaccines can protect your child from disease and illness. And simple tests such as mammograms for women and prostate screenings for men can help find medical symptoms early before a more serious problem develops. Early detection can provide more options for treatment and improve chances of living a longer, healthier life.

To follow is a list of preventive care services covered by the state-sponsored healthcare options. Please keep in mind that these tests and the recommended age criteria are simply guidelines. Your doctor may recommend earlier or more frequent testing due to family history or other health reasons. If medically necessary, these tests will be covered.

Child Immunizations and Checkups

Children through the age of five are covered for 12 well-child visits to physicians, including checkups and immunizations. Annual checkups are covered for children ages 6-17 including immunizations as recommended by the Centers for Disease Control and Prevention (CDC). Your child's doctor can tell you the shots that are needed at certain times and ages. This is an expanded benefit for those in the PPO and POS and will be effective January 1, 2007.

Adult Immunizations and Checkups

Adult preventive care includes one routine physical exam per plan year for ages 18 and over and immunizations including tetanus, measles, mumps, rubella, pneumococcal, influenza and hepatitis B. The physical exam is a new covered benefit for those in the PPO and will be effective January 1, 2007.

Pap Smears

Once during each plan year, female participants can receive a routine OB/GYN well-woman exam. This includes routine breast exam, Pap smear for cervical cancer screening and pelvic exam for those age 18 and over.

Mammogram Screenings

Female participants are covered for one baseline mammogram screening between the ages of 35-39 and then once every plan year for ages 40 and over. Screenings can occur more frequently when prescribed by a physician and determined to be medically necessary.

Cholesterol Screenings

Screenings are covered for those age 40 and over every five years, or more often if medically necessary. This is a new covered benefit for those in the PPO and will be effective January 1, 2007.

Bone Density Scans

Scans for osteoporosis to determine age-related bone loss are available to females age 50 and over once per plan year and as medically necessary for age 65 and over. Scans for men will be covered based on medical necessity. This is a new covered benefit for those in the PPO and will be effective January 1, 2007.

Prostate Screenings

Screenings are covered annually for men who have been treated for prostate cancer with radiation, surgery or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in those individuals found to have elevated PSA levels.

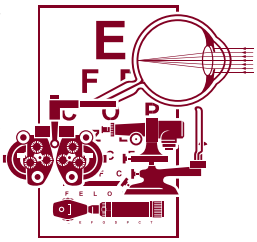
Colorectal Screenings

Beginning at age 50, men and women have one of the following five screening options available: yearly fecal occult blood test, flexible sigmoidoscopy every five years, yearly fecal occult blood test and flexible sigmoidoscopy every five years (preferred over either test alone), double contrast barium enema every five years or colonoscopy every five years. For individuals determined by their physician to be at high risk for colorectal cancer due to medical or family history, screenings may need to begin at an earlier age and occur more frequently.

Vision Care for HMO and POS Participants

While routine vision care (refractive services to determine the need for prescription glasses or contact lens) is not a covered medical benefit under any of the state-sponsored healthcare options, both Cigna Healthcare and United Healthcare offer this service to plan participants as an added benefit of participation in their healthcare options.

Cigna POS and HMO participants may receive one visit per year for a $10 copay provided services are received from a participating Vision Service Plan (VSP) provider. Eligible providers can be located by calling VSP at 1.800.877.7195 or you can search for providers online at www.vsp.com.



United HMO participants may receive one visit per year for a $15 copay provided services are received from a participating Davis Vision provider. A listing of eligible providers is included in the provider directory or you may call member services at 1.877.366.0011 to find a provider in your area.

notable

Under the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema). If you have questions about this act, please call the toll-free telephone number listed on your member identification card.

When adding or cancelling coverage for a dependent, please remember to do so in a timely manner. To add coverage for a newly acquired dependent, an application must be completed within 60 days of the date a dependent is acquired. When you request cancellation, a dependent's coverage will terminate on the last day of the month in which the dependent looses eligibility.

Please be advised that based on federal rules, the new CoverKids program which will be available the first quarter of 2007 is not available to children who are members of a family that is eligible for state employee insurance based on employment with a public agency.

Effective January 1, 2007, the babies first prenatal care program available to PPO and PPO Limited participants will be discontinued. BlueCross BlueShield will be offering a new prenatal program called precious cargo. Individuals wishing to enroll will call 1.800.395.BABY.

In the prepaid dental option offered through Assurant Employee Benefits, the benefit grid lists a routine cleaning as no charge. While there is no charge for the cleaning, the dentist office is allowed to charge a $10 office visit fee. We apologize for any confusion caused by the way this benefit is listed.

ID Cards to be Reissued

All plan members who changed healthcare options during this year's annual transfer period will be issued new ID cards before January 1, 2007. This card must be presented to your doctor, hospital or pharmacy for benefits to be paid.

In addition to those changing healthcare options, all PPO, PPO-Limited and HMO East participants will be issued new cards as outlined below.

HMO East

As communicated to all plan participants during this year's annual transfer period, due to the sale of John Deere's healthcare operations to United Healthcare, participants enrolled in the HMO options in East Tennessee will be covered by United beginning in 2007. All plan participants will be issued a new ID card reflecting this change in claims administrator.

PPO and PPO-Limited

Due to the increase in the copayment for emergency room use to $50, BlueCross BlueShield will be reissuing ID cards to all plan participants as this copayment is referenced on the front of the card. No other information will change.

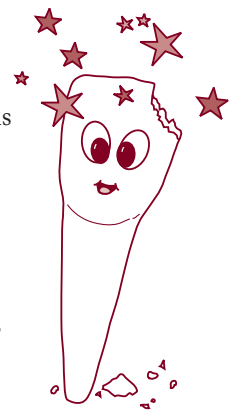
If you are enrolled in one of the healthcare options scheduled to have ID cards reissued and you do not receive one, this could be due to an incorrect home address. Please contact your insurance preparer and verify that your address information is correct. This type of information is not forwardable by the postal service and will be returned if your address is incorrect.

Also remember, any time you need to order additional ID cards, you may do so by calling the insurance company or visiting their web site.

Changes in Delta Dental Waiting Periods

Effective January 1, 2007, Delta Dental will be reducing and, in some instances, eliminating the waiting periods which apply to certain services in the Preferred Dental Organization (PDO) plan. Changes will be as follows:

- The six-month waiting period will be eliminated for endodontics, denture reline and rebase, adjustments to dentures and prefabricated stainless steel or resin crowns.
- The 12-month waiting period will be eliminated for complex oral surgery, major and minor periodontics.
- The 24-month waiting period will be reduced to 12-months for inlay/onlay restorations, crowns, core build-ups or posts and cores, complete or partial dentures, the addition of teeth to existing partial dentures, fixed partial dentures or diagnostic casts.



There is no change in the waiting period for orthodontics—it remains at 12 months.

Waiting periods begin on the effective date of your coverage; therefore, individuals whose dental coverage was effective prior to January 1, 2007, will only have to satisfy the new waiting periods for services in 2007. For example, a member whose coverage was effective on January 1, 2006, will now be eligible for crowns on January 1, 2007, rather than having to wait the 24 months until January 1, 2008. A member whose coverage was effective July 1, 2006, will be eligible for crowns on July 1, 2007.

You know that question that goes through your mind when you take your generic drug? Here's the answer.

What is a generic drug?
When a brand-name drug's patent protection expires, generic versions of the drug can be approved for sale. The generic version works like the brand-name drug in dosage, strength, performance and use, and must meet the same quality and safety standards. All generic drugs must be reviewed and approved by the FDA.

How does FDA ensure that my generic drug is as safe and effective as the brand-name drug?
All generic drugs are put through a rigorous, multi-step review process that includes a review of scientific data on the generic drug's ingredients and performance. FDA also conducts periodic inspections of the manufacturing plant and monitors drug quality—even after the generic drug has been approved.

If generic drugs and brand-name drugs have the same active ingredients, why do they look different?
Generic drugs look different because certain inactive ingredients, such as colors and flavorings, may be different. These ingredients do not affect the performance, safety or effectiveness of the generic drug. In addition, trademark laws in the U.S. do not allow a generic drug to look exactly like other drugs already on the market.

Is my generic drug made by the same company that makes the brand-name drug?
It is possible. Brand-name firms are responsible for manufacturing approximately 50 percent of generic drugs.

Are generic drugs always made in the same kind of facilities as brand-name drugs?
Yes. All generic drug manufacturing facilities must meet FDA's standards of good manufacturing practices. FDA will not permit drugs to be made in substandard facilities. FDA conducts about 3,500 inspections a year to ensure standards are met.

Late Applicant Process Continues for 2007

Under the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA), group health plans must generally comply with the requirement of non-discrimination against individual participants and beneficiaries based on health status. However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from these requirements for self-funded options. All of the state-sponsored health options are self-funded; therefore, the State of Tennessee has elected to exempt the plans from the prohibitions against discriminating against individuals and beneficiaries based on health status in order to allow medical underwriting through a late applicant process.

By requesting this exemption, the state-sponsored plans will be able to continue the process that allows an eligible individual, who is not presently enrolled (late applicant), to enroll in the plan through a medical underwriting or proof of insurability process. The exemption from this federal requirement will continue for the plan year beginning January 1, 2007, and ending December 31, 2007. The election may, but is not required to be, renewed for subsequent plan years.

Eligible employees may apply for coverage for themselves and/or their eligible dependents by submitting medical information about each applicant. Employee eligibility must be verified by the employing agency and a non-refundable application fee is required. Applications may be obtained from your agency insurance preparer or you may print a copy from our web site at www.state.tn.us/finance/ins/ from the publications and forms page.

Other Post Employment Benefits

During the past several years new accounting rules have been introduced that change the way projected costs for healthcare benefits for retirees are reported. You may have read news articles recently concerning these benefits, often referred to as "other post employment benefits" or OPEB. This issue relates to costs to the state for individuals who participate in the state-sponsored insurance plans which continue into retirement.

The OPEB costs are the result of new accounting rules issued by the Governmental Accounting Standards Board (GASB). GASB is an independent body which sets the rules for government accounting and, like other states, Tennessee will continue to comply with the guidelines issued by GASB.

These changes simply affect the reporting of these projected costs and have no effect on the retirement program or healthcare plans that are administered by the state.

These new rules do not require changes to the current plan, and the state has no intention to change current practices, other than to report these costs as a result of this rule change. As part of its compliance with these new reporting guidelines, the state will begin including these projected costs in the financial statements issued by the State of Tennessee beginning June 30, 2008.

Tennessee has a strong history of providing an array of benefit packages to employees and retirees, and we will continue to manage these benefits appropriately in the future. If you have questions about these new reporting requirements, please email your question to opeb.inquiry@state.tn.us.

High Blood Pressure — Know the Numbers

High blood pressure, also called hypertension, is a risk factor for heart and kidney diseases and stroke. This means that having high blood pressure increases your chance (or risk) of getting heart or kidney disease or of having a stroke. This is serious business — heart disease is the number one killer in the United States, and stroke is the third most common cause of death.

About one in every four American adults has high blood pressure. High blood pressure is especially dangerous because it often provides no warning signs or symptoms. And once high blood pressure develops, it usually lasts a lifetime.

Since blood is carried from the heart to all of your body's tissue and organs in vessels called arteries, blood pressure is the force of the blood pushing against the walls of those arteries. In fact, each time the heart beats (about 60-70 times a minute at rest), it pumps out blood into the arteries. Your blood pressure is at its greatest when the heart contracts and is pumping the blood. This is called ***systolic*** pressure. In between beats, when the heart is at rest, your blood pressure falls. This is the ***diastolic*** pressure.

Blood pressure is always given as these two numbers, systolic and diastolic pressures. Both are important. Usually they are written one above or before the other, such as 120/80, with the top number the systolic and the bottom the diastolic.

Different actions make your blood pressure go up or down. For example, when you exert yourself, your blood pressure goes up. When you sleep at night, your blood pressure goes down. These changes are normal.

Some people have blood pressure that stays up all or most of the time. Their blood pushes against the walls of their arteries with higher-than-normal force. If untreated, this can lead to serious medical problems such as hardening of the arteries, heart attack, enlarged heart, kidney damage and stroke.

Anyone can develop high blood pressure, but some people are more likely to develop it than others. In fact, the southeastern states have some of the highest rates of death from stroke and high blood pressure is the key risk factor. Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia have such high rates of stroke among people of all races and in both sexes that they are called the "Stroke Belt States."

A blood pressure of 140/90 or more is considered high. If your blood pressure is between 120/80 and 139/89, then you have prehypertension. This means that you don't have high blood pressure now, but are likely to develop it in the future. People used to think that low blood pressure (for example, 105/65 in an adult) was unhealthy. Except for rare cases, this is not true. High blood pressure or hypertension is classified by stages and is more serious as the numbers get higher.

Everyone can help lower their chance of developing high blood pressure.

- Maintain a healthy weight, or lose weight if you are overweight.
- Increase physical activity.
- Choose foods lower in salt and sodium.
- If you drink alcoholic beverages, do so in moderation.

These rules are also recommended for treating high blood pressure, although medicine is often prescribed as part of the treatment. It is far better to keep your blood pressure from getting high in the first place.

Categories for Blood Pressure Levels in Adults Age 18 and Older

Category	Systolic	Diastolic
Normal	<120	<80
Prehypertension	120-139	80-89
Stage 1 Hypertension	140-159	90-99
Stage 2 Hypertension	≥160	≥100

When systolic and diastolic blood pressures fall into different categories, the higher category should be used to classify blood pressure level. For example, 160/80 would be stage 2 hypertension (high blood pressure). These categories are from the National High Blood Pressure Education Program (www.nhlbi.nih.gov/hbp/).

Subrogation Defined

If you or a covered dependent experiences an illness or injury caused by a third party, your health insurance company has the authority to recover medical expenses from the entity causing the illness or injury or their insurance company. This is called subrogation. Additionally, the insurance company may also subrogate against your own automobile insurance.

Subrogation is a cost containment measure and is standard practice for health insurance. Claims associated with accidental injuries are paid by the state-sponsored plans without delay so that covered individuals are not exposed to collection efforts from healthcare providers.

Once claims resulting from an accidental injury have been paid by the claims administrator, you will receive a questionnaire asking for information relative to the accident. You must respond to that questionnaire and assist in the recovery of the paid claims. Further, you may not settle any claim or lawsuit without express consent.

This is a general description of the subrogation provision and does not alter the specific terms outlined in the *Plan Document*.

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